

Strychnine was given hypodermically. The patient suddenly coughed up a pus-like discharge mixed with mucus, the tube having broken a subglottic abscess. Breathing at once became markedly improved and the pulse stronger. When the patient was discharged, seventeen days after admission, the respirations were only slightly wheezy. On March 10 the patient was again admitted, with temperature 100.6° F., pulse 100, respirations 36, and still wheezy, and with a severe cough. He gradually improved, and when discharged there remained a very slight subglottic stricture.

Dr. W. C. BRAISLIN had found abscesses very common in children after one infection or another, particularly after diphtheria. Early and repeated incisions had given the best results in his experience. Oedematous inflammation soon degenerated into a purulent condition, and for this reason every point at all suggestive of oedema should be incised.

Dr. WALTER B. JOHNSON considered the case detailed in the paper as one of phlegmonous inflammation. Abscess of the larynx of traumatic origin should not be placed in the same category with this severe form of inflammation, in which the abscess is only an incident. The inflammatory condition occurs first and lasts for a considerable time, when the breaking-down and abscess formation occur. The discharge in such cases is not the ordinary purulent discharge met with in abscess of the larynx of traumatic origin.

Dr. WATERMAN, in closing the discussion, said the larynx had not been involved in tuberculosis in the case reported. The tuberculous process was situated in the left apex. Lung involvement seemed to be a rare complication in these cases of laryngeal abscess, as he had found no other similar case reported. He would be interested to see the result of the injection of leucocytes in this class of cases.

*(To be continued.)*

## Abstracts.

### NOSE.

**Coolidge, A., Jun.**—*The Etiology of Common Colds.* "Boston Med. and Surg. Journ.," July 14, 1910.

Among the varieties of acute rhinitis or cold is one form so common and so constant in its symptoms that the author classes it as a distinct and definite disease. He then describes the well-known "cold in the head," and discusses its contagion, spread, and incubation period (two to four days). He believes that such colds never start from "chill," "exposure," or similar popular causes. There is much evidence tending to show that such cases are often directly contagious. The disease is carried by sneezing, coughing, embracing, kissing, speaking at close range, by towels, etc. *Macleod Yearsley.*

**Aikins, W. H. B.**—*Rodent Ulcer of the Nose.* "Canadian Practitioner and Review," May, 1910.

M. L. C.—, aged thirty-four, showed old scar-tissue on the left side of the nose above the wing. The wing itself was entirely destroyed, and the skin around the perforation was covered with the hæmorrhagic granulations of rodent ulcer. The disease dated back to a twig scratch

fifteen years ago. It had been treated in various ways from time to time, and six years ago was scraped for lupus, breaking down afterwards.

The case being referred to Dr. Aikins, he used radium from a flat varnished surface, one centimetre, with a radio-activity of 500,000, at intervals for six weeks, the exposures varying from fifteen to thirty minutes, the course of improvement being watched and the treatment repeated in accordance with the requirements of the case. After the first three exposures improvement commenced, the discharge lessened and the pain ceased. Rapid absorption of the neoplastic tissue took place and healing of the margins followed. Some months later the patient wrote that the nose was in a fine healthy condition, and that there had been no return of the disease. Of course the perforation, with its margins healed, still remained awaiting repair by a plastic operation.

*Price-Brown.*

### PHARYNX.

**Lance, M.**—*When and How should the Tonsils be Removed?* "Gazette des Hopitaux," March 31 and April 2, 1910.

In this article the physiology and embryology of the tonsils are referred to, and the subject of discrimination in their removal is fully discussed. Differing from Bosworth, the writer considers the tonsil a normal organ playing the well-defined rôle of barrier to the inroad of infection, and that this function is exercised so long as its epithelial covering remains intact and it has not become a pathological organ. Simple hypertrophy is not a pathological condition; far from constituting a disease, it is the expression of resistance to infection. In favour of this view it is noted that the subjects of large, soft tonsils projecting into the pharynx are generally robust, healthy children, rarely suffering from cervical adenitis, also that during dentition the tonsils are observed to become enlarged and subsequently diminish. Their removal under these conditions, therefore, only becomes necessary when definite troubles, subsequently to be mentioned, are caused by their presence. Tonsils chronically inflamed demand removal, for they no longer act on the defensive, but become a ready portal for the entry of infection, *e.g.* tuberculosis, septicæmia, pyæmia, phlebitis, acute nephritis, endocarditis, pleurisy, meningitis, appendicitis, and rheumatism; in the cases of the last named, though the pathogenetic entity is unknown, statistics show that removal of chronically inflamed tonsils has a salutary effect on the articular attacks. With regard to tuberculosis, the bacillus may traverse the tonsils without leaving any lesion there, as may obtain in the case of the intestine, but usually lesions are induced with which it is necessary to be acquainted.

Lee, Machard, and Jonathan Wright's description of tubercular tonsils is quoted, as follows: In sickly, anæmic children, the subjects of chronic tonsillitis, in whom the concatenate glands are enlarged and hard, one finds the tonsils pale, small, and submerged, often filling the recess above, and advancing deeply towards the velum. The crypts are filled with caseous matter, which can be expressed with the end of a tongue-depressor; the free border of the anterior faucial pillar is congested. The results of the histological examination of a number of enlarged tonsils are recorded, which substantiate the fact that it is not the large, soft, pedunculated tonsil where tubercular lesions usually occur; they are, for the most part, found in the small, submerged, chronically inflamed tonsil.